Washington Regional

Welcome to Washington Regional – Farmington Family Clinic!

Please complete the attached forms and return them to the office by mail, e-mail, or fax at the address below. Once we receive your packet, we will call you to schedule.

Farmington Family Clinic
199 E. Main St.
Farmington, AR 72730
Fax: 479-463-1026
FarmingtonFamily@wregional.com

If you have insurance, please remember to bring your insurance card, be prepared to pay any required co-payment at your appointment.

Once scheduled, if your appointment is not kept or cancelled at least 24 hours prior to the appointment, it will NOT be rescheduled.

The providers in our clinic do not manage chronic pain or certain psychiatric medications.

If you or your child need immunizations, please call ahead as we are limited on the vaccinations we provide.

Feel free to contact us, if you have any questions, at 479-463-1001.

Thank you,

Washington Regional
Farmington Family Clinic

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PATIENT INFORMATION (PLEASE PRINT)

Name: _____ Date of Birth: ___/___/_____ Sex: □ Male □ Female

Age: _____ Marital Status: _____ Social Security #: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Preferred provider (circle): Jamal Abdin, M.D. or Jantzen Slater, M.D.

Who is responsible for payment: □ Myself □ Other: _____

Guarantor Name: _____ Relationship: _____

Guarantor Phone: _____ Social Security #: _____

Address: _____

Language: □ English □ Spanish □ Other : _____ □ Decline

Race: □ White □ Black □ Hispanic □ Asian □ Native Hawaiian/Other Pacific Islander

□ Native American Indian/Alaskan □ Other _____ □ Decline

Ethnicity (Origin): □ Not Hispanic or Latino □ Hispanic or Latino □ Unknown □ Decline

PATIENT EMPLOYER

Employment Status: □ Full Time □ Part Time □ Unemployed □ Student

□ Retired, date of retirement ____/____/_____

Employer Name: _____

Employer Address: _____

Employer Phone: _____ Occupation: _____

Are you a Veteran: □ Yes □ No If so, have you retired? □ Yes □ No Date of Retirement: _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Location: _____

Mail Order Pharmacy (if desired): _____ Location: _____

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SPOUSE / PARENT INFORMATION

Spouse/Parent Name: _____ Date of Birth: ____/____/_____

Cell: _____ Work Phone: _____

Work Address: _____

Occupation: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Date of Birth: _____

Cell: _____ Home Phone: _____

Address: _____

Relationship: _____ Employment Status: _____

Secondary Emergency Contact: _____ Relationship: _____

Cell: _____ Home Phone: _____

RELEASE OF INFORMATION

Who may we discuss your information with? For example: Medical issues/care, results, billing, etc.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

I authorize release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in the place of the original. I consent for my photo to be taken. I understand that I am responsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys, or insurance companies involved in my care. I give my permission for messages to be left on my answering machine or sent by email. I, the undersigned, authorize and consent to the rendering of medical car, including diagnostic procedures, and medical treatment by authorized members of Washington Regional Medical System or their designees, as may in their professional judgment be necessary for the above-named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Notice of Privacy Practices of the clinic. I permit this facility to obtain my medication history electronically.

X_____ Date:_____

Signature (Patient or Parent/Guardian if minor)

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INSURANCE INFORMATION

Patient Name: _____

PRIMARY INSURANCE

Name of Insurance Company: _____

ID #: _____ Group #: _____

If Medicare managed, Medicare ID # (not social security #): _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Insurance Company's Phone Number: _____

Patient's relationship to Main Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Main Policy Holder's Name: _____ Social Security #: _____

Main Policy Holder's Date of Birth: ____/____/_____

Main Policy Holders Address: _____

City: _____ State: _____ Zip: _____

SECONDARY INSURANCE

Name of Insurance Company: _____

ID #: _____ Group #: _____

If Medicare managed, Medicare ID # (not social security #): _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Insurance Company's Phone Number: _____

Patient's relationship to Main Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Main Policy Holder's Name: _____ Social Security #: _____

Main Policy Holder's Date of Birth: ____/____/_____

Main Policy Holders Address: _____

City: _____ State: _____ Zip: _____

REFERRAL - Have you been a patient at one of our Washington Regional Medical System Clinics?

☐ Yes ☐ No If so, Where: _____ When: _____

Who referred you to our clinic? ☐ Washington Regional Medical Center ☐ Friend/Family ☐ Drove by Location of Clinic

☐ Newspaper/Magazine ☐ Internet/Social Media ☐ Employer ☐ Other: _____

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New Patient Medical History

Please complete this two-sided form prior to your first appointment

Name: _____ Date of Birth: ___/___/ _____ Age: ____ Sex: ____

♦ Please briefly state in the box below the reason for your visit ♦

♦ Review of Systems ♦

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

❑ ***Place an "X" in the box to the left if you have none of the above.***

♦ Past Medical History ♦

Condition / Disease	*Year Began*	*Condition / Disease*	*Year Began*
❑ Hypertension		❑ Heart Rhythm problems	
❑ High Cholesterol		❒ Asthma	
❑ Hypothyroidism (low thyroid)		❒ Cancer	
❑ COPD or Emphysema		❒ Liver Disease	
❑ Diabetes		❒ Kidney Disease	
❑ GERD		❒ Seizure Disorder	
❑ Depression or Anxiety			
❑ Heart Attacks or Blocked arteries			

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♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦			
Operations / Hospitalizations / Injuries	**Month / Yr**	**Operations / Hospitalizations / Injuries**	**Month / Yr**
	/		/
	/		/
	/		/

♦ Family Health History ♦ *Please list below the health history of your blood (genetic) first degree relatives*				
Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				

♦ Social, Educational and Work History ♦		
Marital Status?	Age of children, if any?	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation?	Religious Preference?
Highest Level of Education:	What is your native language?	
What amount of family or social support do you have? Good/Poor/None		
Who all lives in your home?		
Do you use any illegal drugs? Yes/no If so what kind?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?	Do you use E-cigarettes or Vape?	
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	Have you had more than 2 partners in the last 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

♦ Other Physicians and Specialists ♦ *List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)*

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♦ Medications, Vitamins and Herbal Supplements ♦

Medication	Strength	Number of pills taken & frequency	Medication	Strength	Number of pills taken & frequency
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	Reaction	Medication / Food	Reaction

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

♦ ***Immunizations***	***Date(s)***	***Immunizations***	***Date(s)***
Flu		Hepatitis B Vaccine	
Shingles or Shingrix		Gardasil Vaccine	
Pneumonia (Prevnar, Pneumovax) or both?		COVID Vaccine, please circle type:	
		Moderna Pfizer Janssen	
Tetanus or Tdap			

♦ ***Health Screening***	***Date***	***Name and Location of Facility***	***Results- Normal or Abnormal***
Eye Exam			
Colon Cancer screening: colonoscopy, Cologuard, or testing stool for blood			
Mammogram			
Pap Smear			